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FILE COPY

Edwin Dahlberg
St Lukes Regional Medical Center
190 East Bannock
Boise, ID 83712

Dear Mr. Dahlberg:

On July 20, 2006, a complaint investigation survey was conducted at St Luke's Regional Medical Center. The survey was conducted by Penny Salow, Registered Nurse. This report outlines the findings of our investigation.

Complaint # ID00001504

Allegations: A long term care resident was sent to the hospital for emergent care. During his hospitalization, the patient's ischial decubitus ulcer was cultured. The LTC facility was not notified of the results of the culture, which was positive for MRSA, for nearly 2 months.

Findings: An unnannounced visit was made to investigate the complaint. During the investigation, staff were interviewed and reviews were conducted of clinical records, policies and infection control information.
The patient, a 52 year old male, was admitted from a long term care (LTC) facility on 3/9/06, with diagnoses including cellulitis of the left lower extremity, anemia, diabetes and quadriplegia. The admission assessment described an "ischial buttock wound" and "scars from old healed gluteal region ulcerations". The presence of a wound VAC was noted. Documentation indicated the patient's wound was actively treated by the wound clinic "at the Idaho Elks" (Rehabilitation Hospital) prior to admission, and that care would resume following discharge. The record also indicated the patient was prescribed intravenous antibiotics to treat the cellulitis. The record contained a physician's order, dated 3/11/06, that stated "Wound care nursing - please culture wound @ next dressing change". According to the record, a culture of the wound was performed by the hospital's (St. Luke's) wound care staff on 3/13/06, at the time of the wound care. The patient was discharged back to the

LTC facility later that day. The transfer documentation did not contain information related to the results of the culture, as the results were not known for 48 hours. The results of the wound culture were read on 3/15/06, two days after the patient was discharged. The report stated "few methicillin resistant staph aureas (MRSA) isolated". The report indicated the wound infection was susceptable to the antibiotics ordered at the time of admission. The culture report was printed on 3/17/06 and entered as part of the patient's closed record. No documentation was found on the culture report, or otherwise in the record, that anyone, including the physician who ordered the culture or the LTC facility, had been notified of the result. No evidence was found to show that LTC staff contacted the hospital to request the results of the culture, since the patient had returned prior to the results being known.
An infection control officer was interviewed on 7/20/06 at 11:10 AM and the patient's record, as well as the hospital's infection control policies and program, were reviewed. She stated that once the patient was discharged, the only staff who had access to the patient's record, including the culture report, were health information management staff. She stated the community-acquired MRSA rate was 30-40%, so the hospital's medical staff determined it was no longer possible to track all of the culture reports and provide notification. She stated the ordering physician was responsibe to follow up on their own.
A member of the wound care staff, interviewed on 7/20/06 at 11:30 AM, stated that when the patient was transferred back to the LTC facility, the wound care team from the Idaho Elk's resumed management of the wound. The wound care team did not have access to the patient's record or know the results of the culture taken on 3/13/06.
A visit was made to Idaho Elk's Rehabilitation Hospital. A registered nurse from the wound care team was interviewed on 7/20/06 at 1 PM and the patient's lengthy file was reviewed. She stated the team provided oversight of and management of the patient's wound care, but the actual dressing changes were performed by staff at the LTC facility. The wounds were evaluated, treated and cultured, as indicated at the Elk's, whenever the patient had appointments with the physician or nurse practitioner.
Documentation in the patient's file indicated the patient had MRSA in the wound periodically. For example, a culture on 2/25/05 was positive for MRSA. After antibiotic therapy, the infection cleared. When the patient was hospitalized on 3/9/06, a wound culture was again positive for MRSA. No MRSA was identified on a repeat culture on 3/23/06. The patient was hospitalized again in April, 2006, and MRSA was found in the wound. A culture by the Elk's on 5/11/06 was again positive for MRSA. When re-cultured on 5/25/06, the MRSA was no longer present. Each time MRSA was found, the patient was given appropriate antibiotics.

Conclusion: Based on the information, the complaint was substantiated. It was determined that the hospital did not provide, nor did the LTC facility request, the results of the wound culture performed on 3/13/06. However, although the LTC facility was not notified of the results of that wound culture, the LTC facility was aware, based on the patient's history, that the wound could be infected with MRSA at any time. Therefore, the LTC facility would be expected to consistently treat the patient's wound as if MRSA was present.

The hospital maintained a hospital-wide infection control program and no deficient practice was identified. No issues related to discharge planning were identified. No deficiencies were cited.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

PENNY SALOW, RN
Team Leader
Health Facility Surveyor

SYLVIS CRESWELL
Supervisor
Non-Long Term Care

PS/mlw